FORT WAYNE PEDIATRICS

DEMOGRAPHICS

Date: _____

Patient 1 First Name: _____ Last Name: _____ DOB: _____

Ethnicity (circle one that best describes patient):

Native American or Alaskan Native White/Caucasian Hispanic
Black or African American Asian/Pacific Islander Multiple

☐ Male ☐ Female

☐ Adopted ☐ Foster ☐ Biological

Address: _____City:_____State:_____Zip:_____

Patient 2 First Name: _____ Last Name: _____ DOB: _____

Ethnicity (circle one that best describes patient):

Native American or Alaskan Native White/Caucasian Hispanic
Black or African American Asian/Pacific Islander Multiple

☐ Male ☐ Female

☐ Adopted ☐ Foster ☐ Biological

Address: _____City:_____State:_____Zip:_____

Patient 3 First Name: _____ Last Name: _____ DOB: _____

Ethnicity (circle one that best describes patient):

Native American or Alaskan Native White/Caucasian Hispanic
Black or African American Asian/Pacific Islander Multiple

☐ Male ☐ Female

☐ Adopted ☐ Foster ☐ Biological

Address: _____City:_____State:_____Zip:_____

If P.O. Box is mailing address, please state street address: _____

Parent 1 Name: _____ SS#:_____ DOB: _____

Address: _____City:_____State:_____Zip:_____

Cell Phone: _____ Home Phone: _____

Employer_____ Work Phone: _____

Employer Address: _____City:_____State:_____Zip:_____

Parent 2 Name: _____ SS#:_____ DOB: _____

Address: _____City:_____State:_____Zip:_____

Cell Phone: _____ Home Phone: _____

Employer_____ Work Phone: _____

Employer Address: _____City:_____State:_____Zip:_____

Emergency Contact: _____ Relationship: _____ Phone: _____

*****PLEASE SIGN*****

Date: _____ Signature: _____Printed Name: _____

Guardian or Adult Patient (if age 18+)